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Health Technology Work Group Minutes
January 31, 2012

Attendance

Lori Reed-Fourquet; Time Deschenes Desmond, John Vittner, Roderick Bremby, Victor Villagra, Peter Zelez, Roberta Schmidt, Cheryl Waumo, Mark Raymond.

By phone: Vanessa Kapral

Update on the Interim Report

Victor Villagra began the meeting by asking Roderick Bremby for an update on producing an interim report for the Health Care Cabinet.

Roderick Bremby provides an update on the progress of the interim report due in mid-February. He advises the members of the workgroup to look at the recommendations developed by previous groups, for example the Sustinet board, to see how their recommendations fit with current recommendations intended for the interim report. He reminds the group to “take charge to identify 3 achievable goals for this workgroup” to present to the health care board, and he suggests a “completeness check” on issues discussed before including privacy, ownership, stewardship, security and the use of unique identifiers.

Victor Villagra echoes Mr. Bremby in saying that the interim report should make an effort to be inclusive of the advice of predecessors of the health technology workgroup. In particular the Sustinet Health Information Technology group language should be refreshed.

Components of the Interim Report

Mr. Villagra recommends a review of the advice from the following parties: Preventive Services Committee, Provider Quality committee, Patient-Centered Home Committee, Health Disparities and Equity Committee; Three (3) workgroups: Workforce, Tobacco, and Childhood Obesity. He has already completed a high level cross walk of the contents of these reports, focusing on data needs to organize these ideas and harmonize them with the workgroup’s current recommendations. While some advice from previous reports is consistent with the current recommendations, other issues still need to be addressed through future workgroup discussion. The second piece of the interim report might include HITE CT advice and recommendations from Mercer’s report for the health insurance exchange. The third piece of the report should include

recommendations from state agencies gathered through the workgroup presentations. Mr. Villagra asks the workgroup whether there are other groups that have not contributed yet, but may be useful to future development.

Mark Raymond asks for an overall vision from the Health Care Cabinet to align workgroup recommendations. Mr. Villagra responds there is not yet a document with business vision but there has been a fair amount of discussion on federal health reform and the vision is taking shape. The interim report is to address any gap that may exist, with a clearer picture of how we are going along. Mr. Bremby believes the set of recommendation the workgroup will draft should represent a readiness report. The report will not be overall or overarching vision but may identify capabilities as well as some policy issues that need resolution to put technology in supportive posture to achieve an overall health vision. If the workgroup establishes firm recommendations based on the perceived current state we might limit the vision of the larger group as it gets articulated. For example a question early on was “Where do we apply and develop policies regarding the use of personal devices for health maintenance and reform? Can these devices be used to keep people well, and what technology supports do we need to do to put in place to support this? By not addressing mobile devices, it might limit the board in addressing broad vision of health in the context of wellness.” He suggests further conversation of these issues.

Peter Zelez asks whether the report will leverage recommendations from Sustinet, HITE CT and Mercer or rely primarily on the current workgroup recommendations. Mr. Villagra supports new workgroup recommendations.

Discussion of Committee Advice

Victor Villagra initiates a discussion on the recommendation of previous committees. For example, the Preventive Services Committee suggested community based services such as immunizations, screenings completed safely in a community setting. This would expand the locus of prevention to these community settings and ideally be able to communicate back to medical homes. It is unclear how far this workgroup can go with settings outside the medical home.

Lori Reed Fourquet replies that regarding a medical home, there are technologies being built into the infrastructure that notify primary care physician for instance whether there is information available for the patient for example the immunizations, and recommendations for a vaccine forecast through Department of Public Health. This function depends on the ability to set up interfaces between DPH and HITE CT.

Mr. Villagra asks whether there two-way communication between providers, pharmacists and HITE CT. Lori Reed Fourquet replies that pharmacies like Walgreens have not adopted an electronic health record that will communicate with HITE CT. Mr. Villagra asks whether we should be communicating recommendations to non-traditional medical centers, for example chiropractors.

Mr. Bremby believes that the workgroup should have a conversation about the extension of the infrastructure or adequacy of the network if the health cabinet adopts that policy as a direction. Technology must consider that as a set of criteria in recommendations going forward.

Mr. Raymond contributes to the discussion that practical application of the workgroup recommendation is the common need for security. Share information in a trusted way, if business drives itself in that direction, then we will want to be prepared to enter into federated agreements with organizations we do not envision today. We will want to set up technology in a way that we can trust others and not have to re-do security policies.

Discussion of technology to address racial and/or ethnic health disparities

Mr. Villagra says we need technology to create baseline status of health disparities in the state. Mr. Bremby mentions that technology has been used in the past to address health disparities. Project OMB 95 was the forerunner, our recommendation might be that we use adequate fields to capture health disparity information. Lori Reed-Fourquet recommends to use standard vocabularies work at the national level. If we are looking at providing recommendations on a granular level the workgroup should consider the available vocabularies that can assure semantic interoperability. She goes on to say that data collection itself is highly subjective. In order to ensure quality data at its source we may want to require training at this level. Mr. Villagra believes language-based recommendations are of highest priority.

Discussion of enterprise technology to reduce silos of information and share resources

Mr. Deschenes-Desmond comments on the current status of information in silos. A hurdle to Integration of health information is our current status. His department is largely on its own to develop its system but expected to have broad applicability. With the collection of health records and case management, there are pieces of information and processes that are shared. If we develop techniques to share, but at the roots we are flawed, then we must develop systems that are in concert with each other rather than agency to agency differences, specifically on race/ethnicity system. He asks whether there is a case management/EMR system applicable for many agencies.

Mr. Villagra suggests creating an ongoing forum for inter-agency exchange of priorities, synergies and technological capabilities in order to share resources.

John Vittner says a state investment in an enterprise approach has started. The conceptual approach to integrated eligibility system across agencies has been initiated. In parallel to the eligibility system, case management and 12 more examples where there are common business functions across agencies. In context of healthcare, the adoption of solutions and sharing information we need governance structure in place to ease communications, and drive decisions to share information within and across the silos existing today. This is part of the vision we are talking about and with that I'd say we support the approach more broadly to change business practice s and solutions and funding to have sustained investment and accomplish this much more affordably than in the past.

Mr. Zelez comments on information siloes. He says it is a good thing we are going to share information and data in an enterprise system but asks "what are we going to do with the data, and will we be able to act on this data in real time?" A lot of times we have old information and if we have real time data sooner we could conduct trend analysis in real time.

Discussion of other state models of enterprise health IT

Mrs. Schmidt asks if there are other states achieved enterprise models that we can follow. Mr. Raymond responds that Massachusetts has a Secretary of structure collaborate in a different way. Oklahoma is looking at common eligibility system for all system and Michigan is looking for common repositories. It doesn't mean all the info will be in the same location but will ease multiple agencies to access the data and other states have applicable lessons here. We might need to invite leaders nationwide to align our vision. Coordinating across parties is difficult. Technology that goes outside the structure of the agency, and is made for the good of the system it is very difficult to get them funded. We need to find a way to vet decisions as they come up as a group, or here are the recommendations we propose to conform for long term benefits.

Mr. Bremby says the State of Indiana (Corrected: Ohio) is farther along with pulling agencies together. Michigan is doing the same thing. It is our responsibility to co-learn and position ourselves in a way 20 years down the road that we will not be the way we are today. We must take a look at governance approaches, an agreement of the common architecture, and record our desire to do this, in our recommendation.

Discussion of national groups providing state-level support

Mr. Villagra attended an E-health Initiative conference in DC there were a couple of vendors who know how to develop state-wide system with a common architecture that break silos of information. Mr. Deschenes-Desmond comments on national groups offering funding for multi-agency build-out. Agencies looking for funding technical conditions, they want to know scalability and applicability to other state agencies.

Discussion of funding to achieve enterprise-wide infrastructure

Mr. Villagra Suggests that UCONN might be a natural ally to help apply for a quality, comprehensive grant. Cheryl Wamuo says grant writers are available to help agencies come together to jointly apply for multi-agency grants. Mr. Deschenes-Desmond says CMS Standards and Conditions were put out in April last year that support enterprise initiatives. Many CT agencies have been involved to some extent so far, but we are responding mid-way through the process. According to John Vittner there is already momentum to coordinate 5-6 HHS agencies onto the same eligibility system. In regards to funding, Mr. Bremby finds that the Ohio Statewide Data initiative was supported by the Governor's office but there are likely external parties contributing fiscal support as well.

Homework

Mr. Deschenes-Desmond suggests that new conditions and standards for tactical development initiatives be driven by enterprise-wide thinking. The concept behind forward development is to encourage expansion of capacity, interoperability, and scalability, as well as complying with standards. The workgroup is encouraged to think in these terms for their next meeting.

Next Meeting

Mr. Villagra says the workgroup will address data ownership and control policies next time. The workgroup agrees to meet later next week (Feb 6-10th) to review a draft of the interim report, with the knowledge that the report is due February 14, 2012. The group agrees to meet Monthly in 2012.

Public Comment: None

Meeting Adjourned